1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17775

CERTIFICATE OF DEATH

17779

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 107 Bell St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

23-2

3. NAME OF DECEASED (Type or print): First John — Middle EDWARD — Last ADKINS
4. DATE OF DEATH: Month DECEMBER — Day 11 — Year 1967
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 9 1907
9. AGE (In years lost birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief of Police
10b. KIND OF BUSINESS OR INDUSTRY: Town Police Dept.
11. BIRTHPLACE (County & State, or foreign country): Snow Hill Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John H. Adkins
14. MOTHER'S MAIDEN NAME: Rosa Cooper
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 213 01 7560
17. INFORMANT: Gregg Cash — Address: Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular arrest — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): ASCVD. suspected
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-25, 1967 to 12-9, 1967, that (I) (we) last saw the deceased alive on 12-9 1967, and that death occurred at 6:35 AM, from causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/12/67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS: Medical Center Salisbury Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-13-67
23c. NAME OF CEMETERY ~~OR CREMATORY~~: Whitecoat Methodist
23d. LOCATION (City or Town) (County) (State): Snow Hill Maryland
24. FUNERAL DIRECTOR: Truman F. Lemmon — ADDRESS: Snow Hill, Md.
25a. REC'D BY REGISTRAR DATE DEC 15 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17776 17780

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Route #6, Allen Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LANKFORD Middle MUERL Last ANDERSON
4. DATE OF DEATH: Month December Day 26 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 28, 1907
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Bivalve, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Walter Anderson
14. MOTHER'S MAIDEN NAME: Iva Horseman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 220-01-9335
17. INFORMANT: Mrs. Pauline E. Anderson (Wife) Address: Rt. #6, Allen Drive, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
4200
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/6, 1967, to 12/26, 1967, that (I) (we) last saw the deceased alive on Dec 26 1967, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: December 28/1967
22c. PHYSICIAN'S NAME (Type): David J. Gilmore
22d. ADDRESS: Medical Center, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: December 28, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mardela Memorial Cemetery
23d. LOCATION (City, town or county) (State): Mardela, Maryland
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
ADDRESS:
25a. REC'D BY REGISTRAR DATE DEC 29 1967
25b. REGISTRAR'S SIGNATURE

VR A15 (4)
15M 4-64

- 1 -

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

17777

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17781

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3Mos.-5Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Powellville
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

91

22-1

3. NAME OF DECEASED (Type or print): First: Fannie — Middle: Martha — Last: Baker
4. DATE OF DEATH: Month: December — Day: 1 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 11, 1886
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Wicomico County, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: L. Timothy Rayne
14. MOTHER'S MAIDEN NAME: Hennie Martha Lewis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 214-10-9925B
17. INFORMANT: Mr. Horace Baker (Husband) — Address: Powellville, Md.
Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO
(b) Cerebro-vascular Accident — 3 Days
DUE TO
(c) Arteriosclerotic Heart Disease — Years

4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): GeneralizedArteriosclerosis&Metrol&Aortic StenosiscNegurgitation
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/28/67, 19___, to 12/1/67, 19___, that (I) (we) last saw the deceased alive on 12/1/67 19___, and that death occurred at 9:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: A C Mitchell — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/2/67
22c. PHYSICIAN'S NAME (Type): A. C. Mitchell, M.D.
22d. ADDRESS: Box 2018, Salisbury, Maryland-21801

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23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 5, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant Cemetery
23d. LOCATION (City or Town) (County) (State): Powellville, Wic. Co., Md.
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND — ADDRESS
25a. REC'D BY REGISTRAR: DATE DEC 7 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

17778

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17782

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN Ib: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: Route # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Fannie; Middle: Mae; Last: Barber
4. DATE OF DEATH: Month: Dec.; Day: 21; Year: 19 67
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-18-23
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): N.E.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Dempey Fisher
14. MOTHER'S MAIDEN NAME: Edith Wilson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Betty Boulden; Address: 109 Edgewood Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Right Lung — INTERVAL BETWEEN ONSET AND DEATH: ?
163 X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 19, 19 67, to Dec. 21, 19 67, that (I) (we) last saw the deceased alive on Dec. 21, 19 67, and that death occurred at 12:35 P.M. from causes and on the date stated above.

22a. SIGNATURE: L. V. Maldve
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/21/67
22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.
22d. ADDRESS: Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-27-67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
23d. LOCATION (City or Town) (County) (State): Balto. Md.
24. FUNERAL DIRECTOR: Kelson Funeral Home; ADDRESS: 1348 Calhoun St.
25a. REC'D BY REGISTRAR DATE DEC 27 1967
25b. REGISTRAR'S SIGNATURE: Florence Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17779

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17783

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 9 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS: Route # 3 Box 497
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Clayton Middle Lamont Last Beckett
4. DATE OF DEATH: Month 12 Day 12 Year 19 67
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-19-67
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 9 Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: William Dennis
14. MOTHER'S MAIDEN NAME: Bertha ~~[illegible]~~ Beckett
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bertha Cannon, Princess Anne, Md — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Right subdural hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Hours
902.0
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from chair and struck head.
20c. TIME OF INJURY Month, Day, Year: 12-12-67 Hour a.m. A.M. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Own home
20f. (City or town) Princess Anne (County) Somerset (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 12-14-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/16/67
23c. NAME OF CEMETERY OR CREMATORY: St Charles
23d. LOCATION (City or Town) Chance (County) Somerset (State) Md

24. FUNERAL DIRECTOR: William James Jr
ADDRESS: Princess Anne, Md.
25a. REC'D BY REGISTRAR DATE DEC 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME 6M 1/67

7-230281

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17780

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 8 hrs. 51 mins.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield
d. STREET ADDRESS: Peyton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First (Infant) Middle NORMA Last BETTS
4. DATE OF DEATH: Month DECEMBER Day 25 Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 25, 1967
9. AGE (In years last birthday): 0 yrs. — IF UNDER 1 YEAR: Months 0, Days 0 — IF UNDER 24 HRS.: Hours 8, Min. 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - -
10b. KIND OF BUSINESS OR INDUSTRY: - - - - -
11. BIRTHPLACE (County & State, or foreign country): Salisbury-Wicomico-Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jerry Lawson
14. MOTHER'S MAIDEN NAME: Norma Mister
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: - - - -
17. INFORMANT: Address: Clifton Mister -RFD Peyton Rd.-Crisfield, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH 2 hr. 49 min.
761.5
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Delivery by C. Sec. due to Abruptio Placenta
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/25, 1967, to 12/25, 1967, that (I) (we) last saw the deceased alive on 12/25 1967, and that death occurred at 3:05 P.M., from causes and on the date stated above.

22a. SIGNATURE: D. Anderson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/25/67
22c. PHYSICIAN'S NAME (Type): Daniel G. Anderson, M.D.
22d. ADDRESS: Medical Center Bldg. -Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec.26,1967
23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
23d. LOCATION (City or Town) (County) (State): Crisfield, Md. (Somerset)
24. FUNERAL DIRECTOR: Levin R. Wilson - Somerset County, Md. — ADDRESS
25a. REC'D BY REGISTRAR: DATE JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

1

17781

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17785

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS: Rt. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

19-2

3. NAME OF DECEASED (Type or print): First LESTER — Middle IRVING — Last BLOODSWORTH
4. DATE OF DEATH: Month 12 — Day 28 — Year 19 67
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MAY 31,1883
9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MT. VERNON, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: GEORGE BLOODSWORTH
14. MOTHER'S MAIDEN NAME: MARY JONES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MR. DENWOOD BLOODSWORTH — Address: PR. ANNE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b) Arteriosclerotic heart disease — Years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Azotemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from December 5, 19 67, to December 28, 19 67, that (☒ (we) last saw the deceased alive on December 28 19 67, and that death occurred at 9:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: C. H. Winnacott — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/28/67
22c. PHYSICIAN'S NAME (Type): C. H. Winnacott, M. D.
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/30/1967
23c. NAME OF CEMETERY OR CREMATORY: SABURY CEMETERY
23d. LOCATION (City or Town) (County) (State): MT. VERNON, MD.

24. FUNERAL DIRECTOR: LEVIN R. WILSON — ADDRESS: PRINCESS ANNE, MD.
25a. REC'D BY REGISTRAR: DATE JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

A34
4/18/68

1

17782

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17786

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill — 23.2
d. STREET ADDRESS: N. Washington St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: R. Middle: Bruce Last: Blyn
4. DATE OF DEATH: Month: December Day: 25 Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 15, 1892
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Automobile
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Marcus Blyn
14. MOTHER'S MAIDEN NAME: Hessie Ames
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 220-32-0434
17. INFORMANT: Tillie Blyn, Address: Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/1, 19 67 to ____, 19__, that (I) (we) last saw the deceased alive on 12/27, 19 67 and that death occurred at 9 AM, from causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): David J. Gilmore
22d. ADDRESS: Medical Center, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/28/1967
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Whatcoat Methodist
23d. LOCATION (City or Town) (County) (State): Snow Hill Md.
24. FUNERAL DIRECTOR: Gerald C. Lewis — ADDRESS: Snow Hill Md.
25a. REC'D BY REGISTRAR DATE DEC 29 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
20 M 1/66

1 (M)

17783

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17787

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 35 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Galestown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Addie; Middle: W.; Last: Brinsfield
4. DATE OF DEATH: Month: December; Day: 25; Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 18, 1890
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Dorchester, Md.
12. CITIZEN OF WHAT COUNTRY: U.S.
13. FATHER'S NAME: Irvin Wheatley
14. MOTHER'S MAIDEN NAME: Effie Wheatley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 135-36-2233
17. INFORMANT: Mrs. Ernest Suhr — Address: East New Market, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
491X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, Chronic Arthritis, Pernicious Anemia
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Nov 21, 1967 to Dec 25, 1967, that (I) (~~we~~) last saw the deceased alive on Dec 25 1967, and that death occurred at 7:45 P.M. from causes and on the date stated above.

22a. SIGNATURE: Thomas C. Hill Jr., M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 12-25-67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS: Pine Bluff Rd., Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 28, 1967
23c. NAME OF CEMETERY OR CREMATORY: Eldorado
23d. LOCATION (City or Town) (County) (State): Eldorado, Md.
24. FUNERAL DIRECTOR: Newman Funeral Home — ADDRESS: Stockton, Md.
25a. REC'D BY REGISTRAR: DATE JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (A)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17784

CERTIFICATE OF DEATH

17788

1. PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 42 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 242 Martin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

23.2

3. NAME OF DECEASED (Type or print): First: Neva; Middle: Grace; Last: Brittingham
4. DATE OF DEATH: Month: Dec.; Day: 18; Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 2, 1922
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY: Sewing Room
11. BIRTHPLACE (County & State, or foreign country): Snow Hill, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Levin Brittingham
14. MOTHER'S MAIDEN NAME: Olla Pusey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): -------
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Miss Nellie Brittingham, Snow Hill Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
493X
~~XXXXXX~~ DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Carcinoma of cervix with wide spread metastasis — 1 yr.
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 6, 1967, to Dec. 18, 1967 that (I) (we) last saw the deceased alive on Dec. 18 1967, and that death occurred at 2:50 P.M. from causes and on the date stated above.

22a. SIGNATURE: A. C. Mitchell M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/18/67
22c. PHYSICIAN'S NAME (Type): A. C. Mitchell, M. D.
22d. ADDRESS: Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 21/67
23c. NAME OF CEMETERY OR CREMATORY: Bates Methodist
23d. LOCATION (City or Town) (County) (State): Snow Hill, Md.
24. FUNERAL DIRECTOR: Thomas E. Lefevre
ADDRESS: Snow Hill, Md.
25a. REC'D BY REGISTRAR DATE: DEC 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17785 17789

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 418 Dighton Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARTHA Middle: Lost: BROWN
4. DATE OF DEATH: Month: December Day: 1 Year: 19 67
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Apr. 4, 1913
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Factory
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank Brown
14. MOTHER'S MAIDEN NAME: Alice Victor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 219-05-2200
17. INFORMANT: Elizabeth Payne Address: 1402 Holland St. Crum Lynne, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH
4221
DUE TO (b): ASCVD — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Left Ventricular Failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 12-1-67, 19___ to 12-1-67, 19___, that (I) (we) last saw the deceased alive on 12-1-67 19___, and that death occurred at 4:45 M. from causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 1, 1967
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-9-67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Bapt. Cem.
23d. LOCATION (City or Town) (County) (State): Snow Hill, Md. Wor.
24. FUNERAL DIRECTOR: Samuel Lawrence ADDRESS: New Church, Va.
25a. REC'D BY REGISTRAR DATE DEC 5 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (a)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17786 17790

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in 1d 12/20/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 406 Prince Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George Middle Washington Last (BURCHETT) Burchette
4. DATE OF DEATH: Month December Day 31 Year 1967
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 5, 1904
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer-Brick Mason
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Emory Burchette
14. MOTHER'S MAIDEN NAME: Julia Dillard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 237-03-7259
17. INFORMANT: Mrs. Roxie Burchette (Wife) Address: 406 Prince St., Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Weeks
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): pulmonary emphysema
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 26, 1967 to 12/31, 1967, that (I) (we) last saw the deceased alive on 12/30 1967 and that death occurred at 9:00 A.M., from causes and on the date stated above.

22a. SIGNATURE: Sally Beardsley
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/31/67
22c. PHYSICIAN'S NAME (Type): Dr. E.M. Beardsley
22d. ADDRESS: 207 Maryland Ave., Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 3, 1968
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
ADDRESS
25a. REC'D BY REGISTRAR DATE JAN 4 1968
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17787

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17791

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill 23-2
d. STREET ADDRESS: 202 West Martin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edith Middle D. Last Byrd
4. DATE OF DEATH: Month 12 Day 23 Year 19 67
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-28-1890
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Somerset County
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Marcellus Dickenson
14. MOTHER'S MAIDEN NAME: Sarah Davis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 220-32-1218
17. INFORMANT: Mrs. James Onley Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushed chest
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
8164
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of car involved in collision.
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 8 P.M. 12-23-67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Snow Hill Rd.
20f. (City or town) (County) (State): Snow Hill Worcester Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.
22. DATE SIGNED: 12-26-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-26-67
23c. NAME OF CEMETERY OR CREMATORY: Whatcoat Cemetery
23d. LOCATION (City or Town) (County) (State): Snow Hill Worcester Md.

24. FUNERAL DIRECTOR: Donald C. Dennis ADDRESS: Dennis Funeral Home Snow Hill, Md.
25a. REC'D BY REGISTRAR DATE: DEC 29 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17788

CERTIFICATE OF DEATH

17792

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
d. STREET ADDRESS: 208 Walnut St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LESLIE — Middle: GRIFFIN — Last: CALLAHAN

4. DATE OF DEATH: Month: 12 — Day: 6 — Year: 19 67

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 24, 1896
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Retail Clothing
11. BIRTHPLACE (County & State, or foreign country): Worcester County, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Wise Callahan
14. MOTHER'S MAIDEN NAME: Ella Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 219-34-3675
17. INFORMANT: Mrs Robert Westfall, Pocomoke, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO (b): Bronchogenic carcinoma — 3 months
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1621

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from December 4, 19 67, to December 6 19 67, that (I) (we) last saw the deceased alive on December 6 19 67, and that death occurred at 12:30 AM, from causes and on the date stated above.

22a. SIGNATURE: A C Mitchell — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/6/67
22c. PHYSICIAN'S NAME (Type): A. C. Mitchell, M.D.
22d. ADDRESS: Deer's Head State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-9-1967
23c. NAME OF CEMETERY OR ~~CREMATORY~~: St. Mary Episcopal
23d. LOCATION (City or Town) (County) (State): Pocomoke - Wor. - Md.

24. FUNERAL DIRECTOR: Robert H. Watson — ADDRESS: Pocomoke, Md.
25a. REC'D BY REGISTRAR DATE: DEC 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Robert H. Watson

1

FOR STATE HEALTH DEPT.

17789

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17793

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 671 Fitzwater Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sa lisbury
d. STREET ADDRESS: 671 Fitzwater Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

22-1

3. NAME OF DECEASED (Type or print): First George Middle Lost Carney
4. DATE OF DEATH: Month 12 Day 31 Year 19 67
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 7 1934
9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Leon Hawpens
14. MOTHER'S MAIDEN NAME: Sarah ~~Ward~~ Carney
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 228-36-9896
17. INFORMANT: Sarah Ward Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage
982X
DUE TO (b) Stab wound of left popliteal artery
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed behind left knee during domestic quarrel.
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 12-31-67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): own home
20f. (City or town) (County) (State): Salisbury Wicomico Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Ea rl L. Roper, M.D.
Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.
22. DATE SIGNED: 1-2-68

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan 6-68
23c. NAME OF CEMETERY OR CREMATORY: Green Acres Cem
23d. LOCATION (City or Town) (County) (State): Salisbury Wicomico
24. FUNERAL DIRECTOR: West Funeral Home
ADDRESS:
25a. REC'D BY REGISTRAR DATE JAN 4 1968
25b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17790

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17794

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital D.O.A.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 1210 Myrtle Ave., Apt. 103
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: JAMES — Middle: RAY — Last: CHURCH
4. DATE OF DEATH: Month: December — Day: 25 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 9, 1942
9. AGE (In years lost birthday): 25 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Tender -2nd Class - Navy
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mardela, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Earl Johnson Church
14. MOTHER'S MAIDEN NAME: Lola Bell Robinson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 213-42-0582
17. INFORMANT: Mrs. Ann M. Church (Wife) — Address: 1210 Myrtle Ave., Takoma Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fractured skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car that struck bridge.
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:58 P.M. 12-25-67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 13
20f. (City or town) (County) (State): Salisbury Wicomico Md.

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, Md.
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: December 26/1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 28, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mardela Memorial Cemetery
23d. LOCATION (City or Town) (County) (State): Mardela, Maryland
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
ADDRESS:
25a. REC'D BY REGISTRAR — DATE: DEC 28 1967
25b. REGISTRAR'S SIGNATURE:

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17791

CERTIFICATE OF DEATH

17795

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nilton — Middle: ~~Cable~~ — Last: Collins

4. DATE OF DEATH: Month: December — Day: 4 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-27-1918
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): NEWARK, MD
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: ERNEST COLLINS
14. MOTHER'S MAIDEN NAME: MARTHA BETHARDS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ~~If yes~~ give war or dates of service:
16. SOCIAL SECURITY NO.: 231-09-4962
17. INFORMANT: MARTHA COLLINS, Address: Salisbury MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): acute Exacerbation Old Cerebral Thrombosis — 1 year
DUE TO (c): Rheumatic Hemiplegia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Hypertension

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/25/67, 19__, to Nov 4, 1967, that (I) (we) last saw the deceased alive on Nov 4, 1967, and that death occurred at 9 A.M., from causes and on the date stated above.

22a. SIGNATURE: G. Herbert Sembly, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/6/67
22c. PHYSICIAN'S NAME (Type): G. Herbert Sembly
22d. ADDRESS: Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-8-67
23c. NAME OF CEMETERY OR CREMATORY: Evergreen Cem
23d. LOCATION (City or Town) (County) (State): Berlin Md

24. FUNERAL DIRECTOR: West Funeral Home — ADDRESS:
25a. RECD BY REGISTRAR DATE: DEC 11 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1 68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17792

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17797

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: House #11 Nakomis Ave.
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First Vaughn Middle Conway Last
4. DATE OF DEATH: Month 12 Day 8 Year 67 (19)
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 6-16-1919
9. AGE (In years last birthday): 48 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Levin Conway
14. MOTHER'S MAIDEN NAME: Sarah Dashield
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): W.W 11
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sarah Conway Address: Salisbury Md. 11 Nakomis Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
921 X
IMMEDIATE CAUSE (a): Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Shotgun wound of abdomen — Sudden
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot during a quarrel.
20c. TIME OF INJURY Month, Day, Year: Hour 1:30 a.m. p.m. P.M. 12-8-67
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 802 Booth St.
20f. (City or town) (County) (State): Salisbury Wicomico Md.

21. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [X], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.
22. DATE SIGNED: 12-10-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/13/67
23c. NAME OF CEMETERY OR CREMATORY: Green Acres
23d. LOCATION (City or Town) (County) (State): Salisbury Wicomico Md.

24. FUNERAL DIRECTOR: Clinton F. Stewart ADDRESS: West Rod. Salisbury, Md.
25a. REC'D BY REGISTRAR DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17793

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17798

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN Ib:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 906 Spring Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Franklin Middle John Last Cooper
4. DATE OF DEATH: Month 12 Day 3 Year 67 19
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 11-2-1904
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Delivery driver
10b. KIND OF BUSINESS OR INDUSTRY: Wholesale Plumbing
11. BIRTHPLACE (State or foreign country): Worcester County
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Charles M. Cooper
14. MOTHER'S MAIDEN NAME: Martha Truitt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 214-10-9426
17. INFORMANT: Mr. Douglas Cooper Address: Md. Son: 109 Colbourne Drive, Salisbury

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH: Years
~~DUE TO~~ XXX
422.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cirrhosis of the liver — Years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Third degree burns of the right lower leg.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Set pants leg afire while sitting in car.
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 2 P.M. 11-29-67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town) (County) (State): Salisbury Wicomico Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 109 Camden Ave. Salisbury, Md.
22. DATE SIGNED: 12-6-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-6-67
23c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
23d. LOCATION (City or Town) (County) (State): Berlin Worcester Md.

24. FUNERAL DIRECTOR: Holloway and Co. ADDRESS: Salisbury, Md.
25a. REC'D BY REGISTRAR DATE: DEC 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17794

CERTIFICATE OF DEATH

17799

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Delaware
b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel RD 463
d. STREET ADDRESS: rl Pepperbox
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Sue Middle: Ellen Last: Cordrey
4. DATE OF DEATH: Month: December Day: 10 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 17, 1964
9. AGE (In years last birthday): 3 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Leon R. Cordrey
14. MOTHER'S MAIDEN NAME: Minne H. Cordrey, rl Laurel, Del.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Minnie H. Cordrey, rl Laurel Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal Carcinoma
DUE TO (b): Wilm Tumor
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

180 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

3

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/10/67, 19__, to 12/10/67 19__, that (I) (we) last saw the deceased alive on 12/10/67 19__, and that death occurred at 5:50 p.m., from causes and on the date stated above.

22a. SIGNATURE: William C. Morgan M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial k
23b. DATE THEREOF: 12/13/67
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Laurel Del.
24. FUNERAL DIRECTOR: H. R. Jackson ADDRESS: Laurel Del
25a. REC'D BY REGISTRAR DATE: DEC 15 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17795 (5) 17800

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: DELAWARE
b. COUNTY: SUSSEX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MILLSBORO
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

46-3

20

3. NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: Cordrey

4. DATE OF DEATH: Month: December — Day: 26 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG. 5 1927

9. AGE (In years last birthday): 40 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PLANT FOREMAN

10b. KIND OF BUSINESS OR INDUSTRY: POULTRY

11. BIRTHPLACE (County & State, or foreign country): DELAWARE

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANK W. CORDREY

14. MOTHER'S MAIDEN NAME: MARGARET B. CORDREY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 222-20-4331

17. INFORMANT: AUBREY CORDREY — Address: MILLSBORO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracerebral Hemorrhage.
DUE TO
(b): Severe Hypertension.
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

3

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-23, 1967, to 12-26, 1967, that (I) (we) last saw the deceased alive on 12-26-67 19____, and that death occurred at 8 55 AM, from causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald. — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-26-67

22c. PHYSICIAN'S NAME (Type): Joseph C. Fitzgerald

22d. ADDRESS: Medical Center, Salisbury Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12-28-67

23c. NAME OF CEMETERY OR CREMATORY: MILLSBORO CEMETERY

23d. LOCATION (City or Town) (County) (State): MILLSBORO, SUSSEX, DEL.

24. FUNERAL DIRECTOR: A. Douglas Nelson — ADDRESS: Frankford

25a. REC'D BY REGISTRAR: JAN 3 1968 — DATE

25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17796

CERTIFICATE OF DEATH

17801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Spring Hill Private Sanitarium Inc.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
d. STREET ADDRESS: Old Golf Course Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

23.2

90

3. NAME OF DECEASED (Type or print): First PRISCILLA — Middle UPSHUR — Last COVINGTON
4. DATE OF DEATH: Month 12 — Day 11 — Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 5, 1874
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Worcester, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George M. Upshur
14. MOTHER'S MAIDEN NAME: Emma Franklin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ———
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Emily Whaley, Address: Ocean City, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: [illegible]
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

2

21. I certify that (I) (this hospital) attended the deceased from 11, 1967, to 12-11, 1967 that (I) (we) last saw the deceased alive on 12-11 1967, and that death occurred at 6:00 M, from causes and on the date stated above.

22a. SIGNATURE: Wilber R. Ellis Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-12-67
22c. PHYSICIAN'S NAME (Type): Wilber R. Ellis, Jr., M.D.
22d. ADDRESS: Medical Center, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-14-1967
23c. NAME OF CEMETERY OR CREMATORY: All Hallow's Episc. Cem.
23d. LOCATION (City or Town) (County) (State): Snow Hill, Maryland
24. FUNERAL DIRECTOR: Dennis Funeral Home — ADDRESS: Snow Hill, Maryland
25a. REC'D BY REGISTRAR DATE DEC 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17797 Item #11 infor. taken from prev. birth cert.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17802

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manokin
d. STREET ADDRESS: Route # 1 Box 45
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Felissa — Middle: Louella — Last: Curtis
4. DATE OF DEATH: Month 12 — Day 6 — Year 67 (19)
5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-17-67
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months 2, Days 19 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Salisbury, Wic.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
525X IMMEDIATE CAUSE (a) Interstitial pneumonitis
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SUDDEN DEATH IN INFANCY
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 12-7-67

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR: William James Funeral Home — ADDRESS: Princess Anne
25a. REC'D BY REGISTRAR DATE: DEC 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

T-239731

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17798

CERTIFICATE OF DEATH

17803

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Salisbury~~ Tyaskin
d. STREET ADDRESS: Box 1 Tyaskin, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

22-1

3. NAME OF DECEASED (Type or print): First: Milton — Middle: Boyd — Last: Delcher
4. DATE OF DEATH: Month: December — Day: 4 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 15, 1896
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Treasurer
10b. KIND OF BUSINESS OR INDUSTRY: Distillery
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William J. Delcher
14. MOTHER'S MAIDEN NAME: Margaret Boyd
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 165-07-6738
17. INFORMANT: Mrs. Hazel S. Delcher — Address: P.O. Box 1 Tyaskin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a): complete coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO
(b): arteriosclerotic heart disease — 4 yrs
DUE TO
(c): generalized arteriosclerosis — 4 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Tracheobronchitis, diverticulitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 2, 1967, to Dec 4, 1967, that (I) (we) last saw the deceased alive on Dec 4 1967, and that death occurred at 2:55 PM, from causes and on the date stated above.

22a. SIGNATURE: John S. Bulkeley — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-5-67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/8/67
23c. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cemetery
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland
24. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson — ADDRESS: 1050 York Rd. 21204
25a. REC'D BY REGISTRAR — DATE: DEC 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17799

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17806

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 307 East Market Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: J — Last: Donaldson

4. DATE OF DEATH: Month: 12 — Day: 23 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 7-17-1900

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Berlin, Md.

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Willia m F. Jarman

14. MOTHER'S MAIDEN NAME: Mary Gough

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 214-34-9189

17. INFORMANT: Mrs. Jeanne Townsend, Address: Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushed chest — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.

8164

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in car involved in a collision.

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m.: 8 P.M. 12-23-67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Snow Hill Rd.

20f. (City or town): Snow Hill (County): Worcester (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.

22. DATE SIGNED: 12-26-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-26-67

23c. NAME OF CEMETERY OR CREMATORY: All Hallows Cemetery

23d. LOCATION (City or Town) (County) (State): Snow Hill Worcester Md.

24. FUNERAL DIRECTOR: Gerald C. Bounds
ADDRESS: Dennis Funera l Home, Snow Hill, Md.

25a. REC'D BY REGISTRAR DATE: DEC 29 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17800

CERTIFICATE OF DEATH

17805

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Loblolly Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUTH Middle MARIA Last DYKES
4. DATE OF DEATH: Month DECEMBER Day 13 Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/2/1898
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): homemaker
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (County & State, or foreign country): Wicomico, Maryland
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: James Madison Dykes
14. MOTHER'S MAIDEN NAME: Lillie Goslee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Miss Lena R. Dashiell, see # 2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia. — INTERVAL BETWEEN ONSET AND DEATH: 2 hr.
600.0
DUE TO (b) Chronic pyelonephritis — 4 years
DUE TO (c)
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia. ASCV. Disease.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/7/, 1967, to 12/13/1967 that (I) (we) last saw the deceased alive on 12/13/1967, and that death occurred at 11 M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): O. J. Burton, MD
22d. ADDRESS: Medical Center, Salisbury

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/15/1967
23c. NAME OF CEMETERY OR CREMATORY: St. Johns Cemetery
23d. LOCATION (City or Town) (County) (State): Fruitland Wico. Md.
24. FUNERAL DIRECTOR: Franklin B. Hill. ADDRESS: Salisbury
25a. REC'D BY REGISTRAR DATE DEC 21 1967
25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (R)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17801

CERTIFICATE OF DEATH

17806

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 wks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: N. Division St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HELEN Middle Last Elwood
4. DATE OF DEATH: Month DECEMBER Day 1 Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Apr. 24, 1889
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Chicago, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 277-18-5707
17. INFORMANT: Richard J. Elwood — Address: 501 Dogwood dr. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma Ovary Enteritis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1750

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ~~DISEASE CONDITION~~ GIVEN IN PART I(a): Small bowel obstruction
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-28, 1967 to 12-18, 1967 that (I) ~~(we)~~ last saw the deceased alive on 12-18 1967, and that death occurred at 11:45 AM, from causes and on the date stated above.

22a. SIGNATURE: Robert T. Adkins M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-18-67
22c. PHYSICIAN'S NAME (Type): Robert T. Adkins
22d. ADDRESS: Fruitland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/20/1967
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland
24. FUNERAL DIRECTOR: Leroy C. Hill — ADDRESS: Salisbury, Md
25a. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

1

M

17802

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17807

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RURAL PARKSENSBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ROUTE 2

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL PARKSENSBURY
d. STREET ADDRESS: ROUTE 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

22-1

3. NAME OF DECEASED (Type or print): First: SAMUEL Middle: THEODORE Last: ENNIS
4. DATE OF DEATH: Month: DECEMBER Day: 7 Year: 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: APRIL 21, 1880
9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JOHN ENNIS
14. MOTHER'S MAIDEN NAME: MARTHA WHITE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. LULA JENKINS — Address: 106 FOOKS ST. SALISBURY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b): Arteriosclerotic heart dis. — 5 yrs ±
DUE TO
(c):

4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/6, 1966 to death, 19..., that (I) (we) last saw the deceased alive on 12/1 1967, and that death occurred at 4 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Ernest Larmore M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/7/67
22c. PHYSICIAN'S NAME (Type): Ernest M. Larmore
22d. ADDRESS: Delmar, Del.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-9-67
23c. NAME OF CEMETERY OR CREMATORY: BETHEL METH. CH. CEM.
23d. LOCATION (City, town or county) (State): WALSTON WIC. CO. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Thomas F. Wallace — ADDRESS: Salisbury, Md.
25a. REC'D BY REGISTRAR: DATE DEC 8 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Thomas F. WALLACE

VR A1S (4)
20M S-63

7-3-1

17803

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17808

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wicomico Nursing Home, Booth St. Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 411 Franklin Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

22-1

3. NAME OF DECEASED (Type or print): First: Leo — Middle: PATRICK — Last: FEENEY

4. DATE OF DEATH: Month 12 — Day 5 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 8, 1908

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trucker

10b. KIND OF BUSINESS OR INDUSTRY: Produce

11. BIRTHPLACE (County & State, or foreign country): Buffalo, New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Patrick James Feeney

14. MOTHER'S MAIDEN NAME: Emma Garin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214-10-6475

17. INFORMANT: Mrs. Cassie Ellen Feeney (wife) #2 above — Address: Douglas & Charles Feeney (sons)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
DUE TO (b) Carcinoma of colon — 1 yr.
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1538

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/7, 1967, to 12/5, 1967, that (I) (we) last saw the deceased alive on 12/4, 1967, and that death occurred at 8:05 PM, from the causes and on the date stated above.

22a. SIGNATURE: Gaddy Beardsley — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/6/67

22c. PHYSICIAN'S NAME (Type): Dr. E.M. Beardsley

22d. ADDRESS: 207 Maryland Ave., Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND — ADDRESS

25a. REC'D BY REGISTRAR — DATE: DEC 8 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17804 17809

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke 23.2
d. STREET ADDRESS: Route # 2 Box 321B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willie Middle: Lee Last: Fletcher Jr.
4. DATE OF DEATH: Month: 12 Day: 5 Year: 67 (19)
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-2-58
9. AGE (In years last birthday): 9 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Willie Lee Fletcher Sr.
14. MOTHER'S MAIDEN NAME: Lorene Wise
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Lorene Fletcher Address: Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture dislocation of cervical spine — INTERVAL BETWEEN ONSET AND DEATH: Sudden
8124
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Child walking away from schoolbus and struck by car.
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 5:30 P.M. 12-5-67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt. 13 & Beaver Dam Rd.
20f. (City or town): Pocomoke (County): Worcester (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 12-6-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-10-67
23c. NAME OF CEMETERY OR CREMATORY: Hall's Hill Cem.
23d. LOCATION (City or Town) (County) (State): Pocomoke Wor. Md.
24. FUNERAL DIRECTOR: Sam Savage Funeral Home New Church, Va.
ADDRESS
25a. REC'D BY REGISTRAR DATE: DEC 11 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17805 — 17810

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Deal Island
d. STREET ADDRESS: Main Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Christopher — Middle: Mark — Last: Ford
4. DATE OF DEATH: Month: 12 — Day: 19 — Year: 19 67
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ CHILD
8. DATE OF BIRTH: May 18, 1961
9. AGE (In years last birthday): 6 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min. ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child
10b. KIND OF BUSINESS OR INDUSTRY: Student
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas Ford
14. MOTHER'S MAIDEN NAME: Suzie Webster
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT — Address: Thomas Ford Deal Island, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured skull — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
8124
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☒ CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car.
20c. TIME OF INJURY Month, Day, Year Hour a.m.: 5:30 P.M. 12-19-67
20d. INJURY OCCURRED While ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town): Dames Quarter (County): Somerset (State): Md.
21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐
ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.
22. DATE SIGNED: 12-21-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/22/67
23c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery
23d. LOCATION (City or Town): Winona (County): Somerset (State): Md.
24. FUNERAL DIRECTOR: Leroy Webster — ADDRESS: Princess Anne, Md.
25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: [signature]

VR A15ME (5) 6M 1/67

1 (M)

17806

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17811

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Miriam Middle: Powell Last: GREEN
4. DATE OF DEATH: Month: DECEMBER Day: 30 Year: 1967
5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept. 20 1893
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Princess Anne Md. U.S.A.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James H. Powell
14. MOTHER'S MAIDEN NAME: Cornelia Ann Miles
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Howard M. Green Address: Pr. Anne Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
443X
DUE TO (b): Hypertensive C.V. Disease. — Not Known.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/29/, 1967 to 12/30/1967 that (I) (we) last saw the deceased alive on 12/30/1967, and that death occurred at 7:05 A.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/1/68
23c. NAME OF CEMETERY OR CREMATORY: Manokin Mem. Gardens
23d. LOCATION (City or Town) (County) (State): Princess Anne Md
24. FUNERAL DIRECTOR: Felix R. Milburn ADDRESS: Princess Anne Md
25a. REC'D BY REGISTRAR DATE JAN 2 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
20 M 1/66

7 1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17807

CERTIFICATE OF DEATH

17812

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
d. STREET ADDRESS: Pacific Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Russell — Last: Greene Jr
4. DATE OF DEATH: Month: December — Day: 21 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1921
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer
10b. KIND OF BUSINESS OR INDUSTRY: Retail
11. BIRTHPLACE (County & State, or foreign country): Somerset, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: E.R. Greene Sr.
14. MOTHER'S MAIDEN NAME: Nellie Bounds
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 219-07-7210
17. INFORMANT: Mrs. E.R. Greene, Jr — Address: See #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pnemonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b) Carcinomatosis — 6 mos.
DUE TO
(c) Carcinoma Stomach — 1 yr. - app
151 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from 9/21, 1967 to 12/21, 1967, that (I) (~~we~~) last saw the deceased alive on 12/21 1967, and that death occurred at 10:30 A.M. from causes and on the date stated above.

22a. SIGNATURE: John M. Bloxom III — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): John M. Bloxom III
22d. ADDRESS: Medical Ctr., Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/23/1967
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City or Town) (County) (State): Salisbury, Md

24. FUNERAL DIRECTOR: George C. Hill — ADDRESS: Salisbury, Md.
25a. RECD BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (M) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17808

CERTIFICATE OF DEATH

17813

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Mt. Herman Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3. NAME OF DECEASED (Type or print): First DEAN — Middle PERDUE — Last GUNBY
4. DATE OF DEATH: Month 12 — Day 14 — Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 15, 1911
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction
10b. KIND OF BUSINESS OR INDUSTRY: Roads
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: S. Somers Gunby
14. MOTHER'S MAIDEN NAME: Lizzie Perdue
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----
16. SOCIAL SECURITY NO.: 213-12-5382
17. INFORMANT: Mrs. Dean P. Gunby. See Sec 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 day
4201
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

3

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-14, 1967 to 12-14, 1967, that (I) (we) last saw the deceased alive on 12-14 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Wilber R. Ellis Jr. M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-18-67
22c. PHYSICIAN'S NAME (Type): Wilber R. Ellis, Jr., M.D.
22d. ADDRESS: Medical Center, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-17-1967
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: Hill Funeral Home — ADDRESS: Salisbury, Maryland
25a. REC'D BY REGISTRAR DATE DEC 21 1967
25b. REGISTRAR'S SIGNATURE: Norman T. Baker — Clerk, Judge

Norman T. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

1

17809

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17814

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND: Md
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury Md 21-1
d. STREET ADDRESS: 522 Lake ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah Middle: E. Lost: Gunther

4. DATE OF DEATH: Month: Dec Day: 25 Year: 19 67

5. SEX: Female

6. COLOR OR RACE: C

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 10-20-1893

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Wicomico Co

12. CITIZEN OF WHAT COUNTRY?: U S A.

13. FATHER'S NAME: James Nutter

14. MOTHER'S MAIDEN NAME: unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Anna Bayard Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
DUE TO (b) Arteriosclerosis
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200

INTERVAL BETWEEN ONSET AND DEATH: 1 yr. Indefinite

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1 Dec, 1966, to 25 Dec, 1967, that (I) (we) last saw the deceased alive on 25 Dec 1967 and that death occurred at 4 AM from causes and on the date stated above.

22a. SIGNATURE: Purnell M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 29 Dec 67.

22c. PHYSICIAN'S NAME (Type): E. A. Purnell, M.D.

22d. ADDRESS: 652 W Main St., Salisbury Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/31/67

23c. NAME OF CEMETERY OR CREMATORY: Green Acres

23d. LOCATION (City or Town) (County) (State): Salisbury Wicomico Md

24. FUNERAL DIRECTOR: West Funeral Home Berlin Md

ADDRESS: West

25a. REC'D BY REGISTRAR DATE: JAN - 4 1968

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4)
25M 1/67

1

17810

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17816

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn): Salisbury
c. LENGTH OF STAY IN 1b: 40 days
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence befare admissian)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn): Snow Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

23-2

3. NAME OF DECEASED (Type or print): First: Pearl — Middle: E. — Last: Harris
4. DATE OF DEATH: Month: December — Day: 30 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-20-1879
9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of wark dane during mast of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (Caunty & State, ar farein caunty): Snow Hill, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: William Franklin P. Bailey
14. MOTHER'S MAIDEN NAME: Mary A. Dryden
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn): No — (If yes give war ar dates of service): —
16. SOCIAL SECURITY NO.: 220 46 6625
17. INFORMANT: Herbert B. Harris — Address: Snow Hill Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.
DUE TO (b) Generalized Arteriosclerosis — Years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture Rt. Hip, status post-op nailing
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injary in Part I ar Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)
20f. (City ar tawn) (Caunty) (State)

21. I certify that (I) (this haspital) attended the deceased from 11-20, 1967, to 12-30, 1967, that (I) (we) last saw the deceased alive an 12-30 1967, and that death accurred at 6:50 PM, fram causes and an the date stated above.

22a. SIGNATURE: Charles H. Winnacott — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-30-67
22c. PHYSICIAN'S NAME (Type): Charles H. Winnacott
22d. ADDRESS: Deer's Head State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 2, 1968
23c. NAME OF CEMETERY ~~OR CREMATORY~~: Spence Baptist
23d. LOCATION (City ar Tawn) (Caunty) (State): Snow Hill, Md.
24. FUNERAL DIRECTOR: Norman F. Phillips — ADDRESS: Snow Hill, Md.
25a. REC'D BY REGISTRAR: DATE JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

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17811

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17817

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron
d. STREET ADDRESS: Rt #1 Box 85
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Nettie; Middle: C; Last: HAYWARD
4. DATE OF DEATH: Month: DECEMBER; Day: 29; Year: 1967
5. SEX: FEMALE
6. COLOR OR RACE: NEGRO
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 6-17-1890
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Snow Hill
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Sid. Custis
14. MOTHER'S MAIDEN NAME: Lizzie ~~Neal~~ (Unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Virginia Dorman Address: Rt #1 Box 85

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO (b): Recurrent Cerebral Thrombosis — 20 days
DUE TO (c): Hypertensive C.V. Disease — Several yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes, Hypertension
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Aug 25, 1967 to Dec. 29, 1967 that (I) (we) last saw the deceased alive on Dec. 28, 1967, and that death occurred at 10:15 A.M. from causes and on the date stated above.

22a. SIGNATURE: G. Herbert Semblys M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 12/29/67
22c. PHYSICIAN'S NAME (Type): G. Herbert Semblys
22d. ADDRESS: Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-68
23c. NAME OF CEMETERY OR CREMATORY: Green Acres
23d. LOCATION (City or Town) (County) (State): Salisbury Wico. Md.
24. FUNERAL DIRECTOR: Loretta B. Jolley ADDRESS: Jersey Rd. Rt #2 Salisbury, Md
25a. REC'D BY REGISTRAR DATE: JAN 8 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17812

CERTIFICATE OF DEATH

17818

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in Id 10/26/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
d. STREET ADDRESS: R.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARTHA Middle MARY Last HEARNE

4. DATE OF DEATH: Month DECEMBER Day 4 Year 19 67

5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: January 7, 1891
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Willards, Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Staten LaCurts
14. MOTHER'S MAIDEN NAME: Elizabeth Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 220-32-3193
17. INFORMANT: Mr. Orville LaCurts (nephew) Address: Pocomoke City, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 30 d
332X
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-26, 1967, to 12-4, 1967, that (I) (we) last saw the deceased alive on 12-4 19 67 and that death occurred at 8:00 M, from causes and on the date stated above.

22a. SIGNATURE: William R. Ellis M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-4-67
22c. PHYSICIAN'S NAME (Type): Wilbur R. Ellis
22d. ADDRESS: Medical Center, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 7, 1967
23c. NAME OF CEMETERY OR CREMATORY: Willards Cemetery
23d. LOCATION (City or Town) (County) (State): Willards, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
ADDRESS:
25a. REC'D BY REGISTRAR DATE DEC 7 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

17813

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17813

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: DELAWARE
b. COUNTY: SUSSEX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FRANKFORD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

46.3

3. NAME OF DECEASED (Type or print): First: Ocia — Middle: A. — Last: Hudson
4. DATE OF DEATH: Month: December — Day: 2 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-9-1884
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE (RET.)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: SELBY LEWIS
14. MOTHER'S MAIDEN NAME: IRENE E. LEWIS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 222-24-3202
17. INFORMANT: LESTER HUDSON — Address: FRANKFORD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): ASCVD
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute Pancreatitis, Ca of Pancreas suspected.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-27, 1967, to 12-2, 1967, that (I) (we) last saw the deceased alive on 12-2-67 19____, and that death occurred at 11:40 A.M., from causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-2-67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-6-67
23c. NAME OF CEMETERY OR CREMATORY: Carey's Meth. Cem.
23d. LOCATION (City or Town) (County) (State): Frankford, Sussex, Del.
24. FUNERAL DIRECTOR: C. Douglas Melson — ADDRESS: Frankford
25a. REC'D BY REGISTRAR: DATE DEC 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17814

CERTIFICATE OF DEATH

17900

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Henry Middle: J. Last: Johnson
4. DATE OF DEATH: Month: December Day: 28 Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 2-13-1900
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Berlin
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Daniel Johnson
14. MOTHER'S MAIDEN NAME: Lizzie Marshall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sallie Johnson Address: Berlin Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-22, 1967 to 12-28, 1967, that (I) (we) last saw the deceased alive on 12-28 1967, and that death occurred at 8:00 P.M. from causes and on the date stated above.

22a. SIGNATURE: William R. Eddes Jr. M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 1-1-68
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-2-68
23c. NAME OF CEMETERY OR CREMATORY: New Bethel
23d. LOCATION (City or Town) (County) (State): Berlin Wor. Md.
24. FUNERAL DIRECTOR: Loretta E. Jolley ADDRESS: Salisbury, Md.
25a. REC'D BY REGISTRAR DATE: JAN 12 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (8)
20 M 1/66

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17815

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Girdletree
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Robert — Middle: W. — Last: Johnson
4. DATE OF DEATH: Month: December — Day: 27 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 22, 1887
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY: Seafood
11. BIRTHPLACE (County & State, or foreign country): Girdletree, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert W. Johnson
14. MOTHER'S MAIDEN NAME: Jenny Trader
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Elsie R. Johnson — Address: Girdletree, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
332X
DUE TO (b): Cerebral Arteriosclerosis and
DUE TO (c): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of Prostate
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from Dec 27, 1967, to Dec 27, 1967, that (I) (~~we~~) last saw the deceased alive on Dec 27 1967, and that death occurred at 5:55 P.M., from causes and on the date stated above.

22a. SIGNATURE: Thomas C. Hill Jr. M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-27-67
22c. PHYSICIAN'S NAME (Type): Thomas C. Hill Jr.
22d. ADDRESS: Pine Bluff Road, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 30, 1967
23c. NAME OF CEMETERY OR CREMATORY: Beth Eden Cemetery
23d. LOCATION (City or Town) (County) (State): Worcester Co. Maryland
24. FUNERAL DIRECTOR: Norman F. Nemmi — ADDRESS: Snow Hill, Md.
25a. REC'D BY REGISTRAR DATE JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Jones

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17816 17821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in 1 d 12/9/67
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 110 W. Vine Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First (ETTA) Middle GROETTA ARTHUR Last JONES
4. DATE OF DEATH: Month December Day 10 Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 5, 1888
9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (County & State, or foreign country): Hooper's Island, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Arthur Parks
14. MOTHER'S MAIDEN NAME: Mary Dean
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 215-14-3058F2
17. INFORMANT: Mr. Ardie A. Jones (Son) Address: 220 Ballard Ave., Baltimore, Md. 21220

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days
332x
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): degenerative Heart Disease - chronic heart failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 1967, to 12/10, 1967, that (I) (we) last saw the deceased alive on 12-10 1967, and that death occurred at 5:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Earl M. Beardsley
M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: December 11/1967
22c. PHYSICIAN'S NAME (Type): Dr. E.M. Beardsley
22d. ADDRESS: 207 Maryland Ave., Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 13, 1967
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
ADDRESS
25a. REC'D BY REGISTRAR DATE: DEC 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

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15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17817

CERTIFICATE OF DEATH

17822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 1 Bonshice St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Mildred; Middle: Louise; Last: Jones
4. DATE OF DEATH: Month: December; Day: 24; Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 4, 1907
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ernon Sidaway
14. MOTHER'S MAIDEN NAME: Onelta Schrist
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) —
16. SOCIAL SECURITY NO.: 218-16-6589
17. INFORMANT: Wilbur Jones — Address: Snow Hill MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 13 days
4201
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/11, 19 67 to 12/24, 19 67, that (I) (we) last saw the deceased alive on 12/24 19 67, and that death occurred at 4:15 AM, from causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): David W. Gilmore MD
22d. ADDRESS: Medical Center Salisbury MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/28/1967
23c. NAME OF CEMETERY OR CREMATORY: All Hallows Episc Cem.
23d. LOCATION (City or Town) (County) (State): Snow Hill MD.
24. FUNERAL DIRECTOR: Gerald C. Bounds — ADDRESS: Snow Hill MD
25a. REC'D BY REGISTRAR DATE DEC 29 1967
25b. REGISTRAR'S SIGNATURE: Florence Judge

VR A15 (4)
20 M 1-66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17818 17823

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron
d. STREET ADDRESS: Lillian Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

221

3. NAME OF DECEASED (Type or print): First: Rev. — Middle: WILLIAM — Last: HESPIOR KOHL
4. DATE OF DEATH: Month: December — Day: 14 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 25, 1897
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Minister
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Phillipsburg, N. J.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 220-32-0633A
17. INFORMANT: Mrs. Gordy Kline (Daughter) — Address: Lillian St., Hebron, Md.
Mrs. Mabel D. Kohl (Wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks
1533
DUE TO (b) Metastatic Carcinoma — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Carcinoma of Sigmoid Colon — 2 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from November, 1967, to 12-14, 1967, that (I) (~~we~~) last saw the deceased alive on 12-14 1967, and that death occurred at 5:05 PM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec. 15 / 1967
22c. PHYSICIAN'S NAME (Type): Dr. Hunter Mann, Jr.
22d. ADDRESS: 209 Maryland Ave., Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 17, 1967
23c. NAME OF CEMETERY OR CREMATORY: Springhill Memory Gardens
23d. LOCATION (City, town or county) (State): Salisbury, Maryland
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND — ADDRESS
25a. REC'D BY REGISTRAR — DATE: DEC 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17819 — 17824

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in Id 12/29/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. STREET ADDRESS: Rt. #6, Parker Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle WESLEY — Last LAWRENCE
4. DATE OF DEATH: Month December — Day 31 — Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 1, 1906
9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cable Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Telephone Company
11. BIRTHPLACE (County & State, or foreign country): New York City, N. Y.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William G. Lawrence
14. MOTHER'S MAIDEN NAME: Martha Gilmore
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 212-10-0430
17. INFORMANT: Mrs. Charlotte J. Lawrence (Wife) — Address: Rt. #6, Parker Road, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3days
5271
DUE TO (b) Secondary to Pulmonary Emphysema — Few Yr
DUE TO (c) Mild Arteriosclerosis — ??????
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ----------

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐ ##

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) ----------
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar. 28, 19 7, to Dec. 31, 19 67 that (I) (we) last saw the deceased alive on Dec. 31, 19 67, and that death occurred at 4 P.M, from the causes and on the date stated above.

22a. SIGNATURE: G. Herbert Sembly, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Jan. 2, /1968
22c. PHYSICIAN'S NAME (Type): Dr. G. Herbert Sembly
22d. ADDRESS: 400 E. Church St., Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 4, 1968
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND — ADDRESS
25a. REC'D BY REGISTRAR: DATE JAN 4 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

17820

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17825

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 154 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsville
d. STREET ADDRESS: - -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOSEPH Middle WILLIAM Last LITTLETON
4. DATE OF DEATH: Month 12 Day 12 Year 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 5, 1901
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Motorman
10b. KIND OF BUSINESS OR INDUSTRY: City Transit Co.
11. BIRTHPLACE (County & State, or foreign country): Gumboro, Delaware
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: Horace Littleton
14. MOTHER'S MAIDEN NAME: Clara Lewis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 179-03-6820
17. INFORMANT (Address): Mrs. Brenda L. Bradford (Sister) 920 Riverside Drive, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
443X
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b) Acute pulmonary edema — 24 hours
DUE TO
(c) Hypertensive arteriosclerotic heart disease — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from July 11, 1967, to December 12, 1967, that ☒ (we) last saw the deceased alive on December 12, 1967, and that death occurred at 6:15 AM, from causes and on the date stated above.

22a. SIGNATURE: C. H. Winnacott M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/12/67
22c. PHYSICIAN'S NAME (Type): C. H. Winnacott, M.D.
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 14, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Stephens Cemetery
23d. LOCATION (City or Town) (County) (State): Delmar, Delaware
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND — ADDRESS
25a. REC'D BY REGISTRAR DATE DEC 15 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in ID 12/28/67
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 204 Linwood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RUTH; Middle: LUCINDA; Last: Littleton
4. DATE OF DEATH: Month: December; Day: 29; Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 23, 1898
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Wicomico County, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: David H. Tingle
14. MOTHER'S MAIDEN NAME: Martha Parsons
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 217-10-3600 B
17. INFORMANT: Mr. William Z. Littleton (Husband)
Address: 204 Linwood Ave., Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gangrenous st leg — INTERVAL BETWEEN ONSET AND DEATH: 4
DUE TO (b): Diabetic acidosis — hrs
DUE TO (c): Diabetes Mellitus — yrs

260X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 28, 1967, to Dec 29, 1967, that (I) (we) last saw the deceased alive on Dec 29 1967, and that death occurred at 4:05 P.M., from the causes and on the date stated above.

22a. SIGNATURE: John T. Bulkeley
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-29-67
22c. PHYSICIAN'S NAME (Type): John T Bulkeley
22d. ADDRESS: Pine Bluff Road, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 2, 1968
23c. NAME OF CEMETERY OR CREMATORY: Springhill Memory Gardens
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
ADDRESS:
25a. REC'D BY REGISTRAR DATE: JAN 4 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

17822

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17827

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS: Antioch Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Everett — Middle: Hayman — Last: Long
4. DATE OF DEATH: Month: 12 — Day: 3 — Year: 19 67
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-14-12
9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Ira Oscar Long
14. MOTHER'S MAIDEN NAME: Jennie Hayman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.
22. DATE SIGNED: 12-4-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/5/67
23c. NAME OF CEMETERY OR CREMATORY: Beechwood Cemetery
23d. LOCATION (City or Town) Princess Anne (County) Somerset (State) Md.
24. FUNERAL DIRECTOR: James L. Hinman
ADDRESS: Princess Anne, Md.
25a. REC'D BY REGISTRAR DATE DEC 7 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

4 I

FOR STATE HEALTH DEPT.

I

17823

Item #1b & d Film #G396 12/27/67 ph

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17828

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown
d. STREET ADDRESS: Corporation Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Henry Middle Paul Last Lundy
4. DATE OF DEATH: Month 12 Day 8 Year 67 (19)
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Apr. 4, 1895
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): contractor
10b. KIND OF BUSINESS OR INDUSTRY: home bldgs.
11. BIRTHPLACE (State or foreign country): Traer, Iowa
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Henry Lundy
14. MOTHER'S MAIDEN NAME: Charlotte Every
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Neal E. Lundy, Address: Sharptown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b) Arteriosclerotic cardiovascular disease — Years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.
22. DATE SIGNED: 12-8-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/12/67
23c. NAME OF CEMETERY OR CREMATORY: Maple Grove Cemetery
23d. LOCATION (City or Town) (County) (State): Mason Michigan
24. FUNERAL DIRECTOR: W. Dishaw Lund Dela.
ADDRESS
25a. REC'D BY REGISTRAR DATE DEC 15 1967
25b. REGISTRAR'S SIGNATURE: Charles Jenkins

VR A15ME (5) 6M 1/67

2

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17824

CERTIFICATE OF DEATH

17829

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishopville
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Lillie Middle: M. Last: McCabe
4. DATE OF DEATH: Month: December Day: 2 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 1, 1884
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William H. Holloway
14. MOTHER'S MAIDEN NAME: Elizabeth Davidson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): XX (If yes give war or dates of service): XX
16. SOCIAL SECURITY NO.: XX
17. INFORMANT: James F. McCabe Showell, Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Acute Myocardial Infarction — 5 days
DUE TO
(c): ASCVD.
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Right hemiparesis, senility, obesity
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-27, 1967 to 12-2, 1967, that (I) (we) last saw the deceased alive on 12-2 1967, and that death occurred at 6 P M, from causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 12-2-67.
22c. PHYSICIAN'S NAME (Type): Joseph C. Fitzgerald
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/5/67
23c. NAME OF CEMETERY OR CREMATORY: Odd Fellows
23d. LOCATION (City or Town) (County) (State): BISHOPVILLE Md.
24. FUNERAL DIRECTOR: Watson & Wholey, Sellyville, Md. ADDRESS
25a. REC'D BY REGISTRAR DATE DEC 7 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17825

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17830

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN Ib: -
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton
d. STREET ADDRESS: Bird Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

23-2

3. NAME OF DECEASED (Type or print): First Kenneth Middle Allen Last Merrick
4. DATE OF DEATH: Month 12 Day 14 Year 67 (19)
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-9-67
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 3 Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): SALISBURY, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert Merrick
14. MOTHER'S MAIDEN NAME: Maxine GLEATON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: ROBERT H. MERRICK Address: STOCKTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Interstitial pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: days
525
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SUDDEN DEATH IN INFANCY
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.
22. DATE SIGNED: 12-14-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: DEC. 16-1967
23c. NAME OF CEMETERY OR CREMATORY: FIRST BAPTIST CEM
23d. LOCATION (City or Town) (County) (State): POCOMOKE CITY, WORCESTER
24. FUNERAL DIRECTOR: Watson Funeral Home ADDRESS: Pocomoke, Md.
25a. REC'D BY REGISTRAR DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

7-234757

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17826 17831

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wicomico Nursing Home, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE: Md. b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nanticoke
d. STREET ADDRESS: 22-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella Middle: Frances Last: Messick
4. DATE OF DEATH: Month: Dec. Day: 20 Year: 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/6/1871
9. AGE (In years last birthday): 96 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Wicomico, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: George W. Messick
14. MOTHER'S MAIDEN NAME: Mitilda Evans
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs Blanche Cox Address: Nanticoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — Hours
DUE TO (b) generalized atherosclerosis — yrs.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332 A
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Degenerative heart disease.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/22, 1967, to 12-20, 1967, that (I) (we) last saw the deceased alive on 12-20 1967, and that death occurred at 8:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Earl Beardsley — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/20/67
22c. PHYSICIAN'S NAME (Type): Earl Beardsley
22d. ADDRESS: Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/23/67
23c. NAME OF CEMETERY OR CREMATORY: Turners Cem.
23d. LOCATION (City, town or county) (State): Nanticoke, Md.
24. FUNERAL DIRECTOR: C. Messick ADDRESS: Bivalve, Md.
25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
2DM 1/65

17827

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17832

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, crematian, ar remaval, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Royal Oak — 20.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Russell — Middle: T. — Last:
4. DATE OF DEATH: Month: December — Day: 23 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/6/1903
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner Sheet Metal Shop
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Lawrence Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Miles
14. MOTHER'S MAIDEN NAME: Olive Polly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 177-03-7229
17. INFORMANT: Address: Mrs. Russell Miles, Royal Oak, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Tracheo - Bronchitus, acute — INTERVAL BETWEEN ONSET AND DEATH: days
5020
DUE TO
(b) Bronchopneumonia — days
DUE TO
(c) Emphysema — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Duodenal Ulcers with bleeding - weeks
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 19, 1967, to Dec. 23, 1967, that (I) (we) last saw the deceased alive an Dec. 23, 1967, and that death accurred at 7 A M, fram causes and an the date stated abave.

22a. SIGNATURE: A C Mitchell — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/24/67
22c. PHYSICIAN'S NAME (Type): A. C. Mitchell, MD.
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/26/1967
23c. NAME OF CEMETERY OR CREMATORY: Spring Hill
23d. LOCATION (City or Town) (County) (State): Easton, Md.

24. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON
ADDRESS: Easton, Md.
25a. REC'D BY REGISTRAR DATE JAN 2 1968
25b. REGISTRAR'S SIGNATURE: James Judge

VR A15 (4)
25M 1/67

3 1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17828 17833

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in 1-D 12-6-67
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 311 Carey Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: ANN — Last: MOSLEY

4. DATE OF DEATH: Month: DEC. — Day: 9th — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Jan. 12/1912

9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee-Laborer-Shirt Factory

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Accomac Co., Virginia

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Jacob Campbell

14. MOTHER'S MAIDEN NAME: Annie Emily Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-10-7629

17. INFORMANT — Address: Mr. Charles E. Mosley (Husband) - Item #2 above; Mr. Wm. C. Mosley (Son) R.D.#7 Salisbury, Md. Glen Ave. Ext. 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO (b): Cerebral Hemorrhage
DUE TO (c): Peripheral Vascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1992

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ....., 19..., to ....., 19....., that (I) (we) last saw the deceased alive on ....., 19....., and that death occurred at App. 5:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Carrie H Hearn M.D. — M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Dec. 11/1967

22c. PHYSICIAN'S NAME (Type): Dr. Carrie I. Hearn

22d. ADDRESS: N. Division St. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 11/1967

23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR — DATE: DEC 13 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
15M 7-62

1

17829

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17834

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 421 Robbins Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CECIL Middle JONES Last MURPHY
4. DATE OF DEATH: Month 12 Day 27 Year 19 67
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 7, 1892
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Frank H. Jones
14. MOTHER'S MAIDEN NAME: Annie Insley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): - - -
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Mr. O'Neill Murphy, Address: Cambridge, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Hypertensive arteriosclerotic cardiovascular disease — Years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Previous CVA - 10/23/67
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (X) (this hospital) attended the deceased from December 11, 19 67, to December 27, 19 67, that (I) (X) (we) last saw the deceased alive on December 27 19 67, and that death occurred at 6:05 P.M., from causes and on the date stated above.

22a. SIGNATURE: A C Mitchell, M.D.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/28/67
22c. PHYSICIAN'S NAME (Type): A. C. Mitchell, M. D.
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec 31 1967
23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park
23d. LOCATION (City or Town) (County) (State): Cambridge, Maryland
24. FUNERAL DIRECTOR: LeCompte Funeral Service
ADDRESS: Cambridge, Maryland
25a. REC'D BY REGISTRAR DATE JAN 3 1968
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17830

CERTIFICATE OF DEATH

17835

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 421 Oak Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ERMAL — Middle MAE — Last PARKER
4. DATE OF DEATH: Month DECEMBER — Day 5 — Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 8, 1899
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Laborer
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (County & State, or foreign country): Pittsville, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Clem Elliott
14. MOTHER'S MAIDEN NAME: Charlotte Holloway
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 218-34-8859
17. INFORMANT: Mrs. Clara Bell (Daughter) — Address: 421 Oak Street, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus - Generalized arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1967, to 12/5, 1967, that (I) (we) last saw the deceased alive on 12/5 1967, and that death occurred at 2:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Earl Beardsley, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: December 5, 1967
22c. PHYSICIAN'S NAME (Type): EARL Beardsley
22d. ADDRESS: Maryland Ave. Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 7, 1967
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND — ADDRESS
25a. REC'D BY REGISTRAR — DATE DEC 8 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Items 18-21 Film 396
1-8-68 ams
17831

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17836

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 713 Dennis Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 713 Dennis Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

22-1

3. NAME OF DECEASED (Type or print): First: Lillian — Middle: — Last: Parker
4. DATE OF DEATH: Month 12 — Day 19 — Year 67
5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 6/17/1921
9. AGE (In years last birthday): 46 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Benjamin Richards
14. MOTHER'S MAIDEN NAME: Leolis Richards
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Leolis Richards — Address: Hampton, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Exposure to cold — INTERVAL BETWEEN ONSET AND DEATH: days
932.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic alcoholism
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Alcoholic at home alone with no heat.
20c. TIME OF INJURY Month, Day, Year: 12-19 1967 — Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Own home
20f. (City or town) (County) (State): Salisbury Wicomico Md.

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.
22. DATE SIGNED: 12-21-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/31/67
23c. NAME OF CEMETERY OR CREMATORY: Hall Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Pocomoke Worchester Md.
24. FUNERAL DIRECTOR: Clinton F. Stewart — ADDRESS: Salis Md.
25a. REC'D BY REGISTRAR — DATE: DEC 28 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME(5)
6M 1/67

1

17832

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17837

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 29 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 422 Stewart Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JAMES — Middle: — Last: PARSONS

4. DATE OF DEATH: Month: 12 — Day: 13 — Year: 19 67

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/5/1912
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Parsons
14. MOTHER'S MAIDEN NAME: Fannie Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Primary carcinoma of the esophagus with metastasis to regional lymphnodes
150 x
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 4 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from November 14, 19 67, to December 13 19 67, that (I) (we) last saw the deceased alive on December 13 19 67, and that death accurred at 6:35 PM, from causes and on the date stated above.

22a. SIGNATURE: C H Winnacott M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/14/67
22c. PHYSICIAN'S NAME (Type): C. H. Winnacott, M.D.
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/17/ 67
23c. NAME OF CEMETERY OR CREMATORY: Green Acres
23d. LOCATION (City or Town) (County) (State): Salisbury Wicomico Md.

24. FUNERAL DIRECTOR: Clinton F. Stewart Sals - Md.
ADDRESS:
25a. REC'D BY REGISTRAR DATE: DEC 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Judy

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17833

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17838

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3,670 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 704 Goldsboro Street ~~705 Howard Street~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

22-1

3. NAME OF DECEASED (Type or print): First BERTIE — Middle MAE — Last PRYOR
4. DATE OF DEATH: Month 12 — Day 27 — Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 7, 1885
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Crisfield, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Isaac Byrd
14. MOTHER'S MAIDEN NAME: Marion Stevenson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: --
17. INFORMANT: Mr. Charles E. Pryor (Husband) — Address: 704 Goldsboro, St., Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subtotal coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: --
DUE TO (b) Arteriosclerotic cardiovascular disease — Years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Old cerebral thrombosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from December 9, 1957 to December 27, 1967, that (X) (we) last saw the deceased alive on December 27 1967, and that death occurred at 5:20 PM, from causes and on the date stated above.

22a. SIGNATURE: L. V. Maldve, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/28/67
22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.
22d. ADDRESS: Deer's Head State Hospital, Salisbury ~~Maryland~~

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 30, 1967
23c. NAME OF CEMETERY OR CREMATORY: Springhill Memory Gardens
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND — ADDRESS
25a. REC'D BY REGISTRAR DATE: JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17834

CERTIFICATE OF DEATH

17839

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 22 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: R.D.#3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

09-2

91

3. NAME OF DECEASED (Type or print): First: George — Middle: B. — Last: Robbins

4. DATE OF DEATH: Month: December — Day: 29 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☒

8. DATE OF BIRTH: Sept. ?, 1885

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watermann

10b. KIND OF BUSINESS OR INDUSTRY: Seafood

11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Robbins

14. MOTHER'S MAIDEN NAME: Louise Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): - - -

16. SOCIAL SECURITY NO.: unk

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho-Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48hrs.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

491 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Thrombosis - R. T. Hemiplegia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/7/67, 19___, to 12/29/67, 19___, that (I) (we) last saw the deceased alive on 12/29/67 19___, and that death occurred at 11P. M, from causes and on the date stated above.

22a. SIGNATURE: Charles H Winnacott — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12/30/67

22c. PHYSICIAN'S NAME (Type): Charles H. Winnacott, M.D.

22d. ADDRESS: Box 2018, Salisbury, Md. - 21801

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23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan 1, 1968

23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery

23d. LOCATION (City or Town) (County) (State): Cambridge, Maryland

24. FUNERAL DIRECTOR — ADDRESS: LeCompte Funeral Service, Cambridge, Maryland

25a. REC'D BY REGISTRAR — DATE: JAN 4 1968

25b. REGISTRAR'S SIGNATURE: J Charles Judge

2 1

17835

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17840

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First Delcie; Middle Mae; Last Roberts
2a. DATE OF DEATH: Month December; Day 17; Year 1967
2b. HOUR: 10 pM
3. SEX: female
4. RACE: colored
5. DATE OF BIRTH: Jan. 2, 1897
6. AGE (In years last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Pine Bluff State Hosp.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Domestic
12b. KIND OF BUSINESS OR INDUSTRY: -
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Worcester
13c. CITY OR TOWN: Pocomoke
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 504 Young Street
14. FATHER'S NAME: First John; Middle -; Last Roberts
15. MOTHER'S MAIDEN NAME: First Lizzie; Middle -; Last Broughton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): -
16b. SOCIAL SECURITY NO.: 224-18-2698
17. INFORMANT: Records of: Address: Pine Bluff State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) chronic nephritis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown
592 X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) ☒ (this hospital) attended the deceased from Oct. 24, 1967, to Dec. 17, 1967, that (I) (we) last saw the deceased alive on Dec. 17 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: E P Ritchings — DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22c. DATE SIGNED: Dec. 18, 1967
22d. PHYSICIAN'S NAME (Type): E. P. Ritchings, M.D., Supt. Pine Bluff State Hospital
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12-24-67
23c. NAME OF CEMETERY OR CREMATORY: Wardtown Cem.
23d. LOCATION (City or Town) (County) (State): Pocomoke Wor. Md.
24. FUNERAL DIRECTOR: Samuel Lowe — ADDRESS: New Church, Va.
25a. REC'D BY REGISTRAR DATE: DEC 22 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A16
30M REV. 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17836

CERTIFICATE OF DEATH

17841

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. STREET ADDRESS: Route 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First VERNON — Middle GRAY — Last Robertson
4. DATE OF DEATH: Month December — Day 8 — Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 14, 1894
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer & Manager
10b. KIND OF BUSINESS OR INDUSTRY: Auto Store
11. BIRTHPLACE (County & State, or foreign country): Bivalve, Maryland
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Charlie Francis Robertson
14. MOTHER'S MAIDEN NAME: Emma J. Downing
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 219-14-3657
17. INFORMANT: Charles V. Robertson (Son) — Address: Route 3, Delmar, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
3327
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 10-23, 1967, to 12-8, 1967, that (I) (we) last saw the deceased alive on 12-8, 1967, and that death occurred at 6:00 A.M., from causes and on the date stated above.

22a. SIGNATURE: Wilber R. Ellis Jr. — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-8-67
22c. PHYSICIAN'S NAME (Type): Dr. Wilber R. Ellis, Jr.
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 10, 1967
23c. NAME OF CEMETERY OR CREMATORY: Grace Episcopal Church Cemetery
23d. LOCATION (City or Town) (County) (State): Mt. Vernon, Maryland
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR — DATE: DEC 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (1)
20 M 1/66

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17831 17842

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in 1 d 11/27/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. STREET ADDRESS: 135 Truitt Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAISEY Middle MAE Last ROSS
4. DATE OF DEATH: Month December Day 27 Year 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 8, 1898
9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Former Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY: Shirt Factory
11. BIRTHPLACE (County & State, or foreign country): Bridgeville, Delaware
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Isaac J. Lecates
14. MOTHER'S MAIDEN NAME: Mary Davis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 214-10-8068
17. INFORMANT: Mr. Vernon H. Ross (Husband) Address: 135 Truitt St., Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinomatosis	2 mo
DUE TO (b)	Carcinoma uterus	6 mo.
DUE TO (c)	Intestinal obstruction	10 d.

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at 5:25 PM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec. 28 /1967
22c. PHYSICIAN'S NAME (Type): Dr. E. Kent Carney
22d. ADDRESS: Medical Center, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 30, 1967
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND ADDRESS
25a. REC'D BY REGISTRAR DATE JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17838

CERTIFICATE OF DEATH

17843

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after de
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 12 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
d. STREET ADDRESS: 314 GLEN AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First HERBERT Middle STANLEY Last SCHAAB
4. DATE OF DEATH: Month DECEMBER Day 9 Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 12/7/1903
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED, RECEIVING CLK
10b. KIND OF BUSINESS OR INDUSTRY: BELTING MANUFACTURER
11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: HENRY SCHAAB
14. MOTHER'S MAIDEN NAME: MARY REMENTER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: SHELDON SEIDEL, Address 110 N. DIVISION ST SALISBURY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
4200
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Anemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/7, 1967 to 12/19, 1967, that (I) (we) last saw the deceased alive on 12/19 1967, and that death occurred at 12 PM, from causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/21/1967
22c. PHYSICIAN'S NAME (Type): DAVID J. GILMORE, MD
22d. ADDRESS: SALISBURY MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/22/1967
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON CEMETERY
23d. (City or Town) (County) (State): ~~SALISBURY MD~~ PHILADELPHIA PA.

24. FUNERAL DIRECTOR: Hill Funeral Home
ADDRESS: Salisbury, Md.
25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

1

17839

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17844

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 305 Middle Blvd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 305 Middle Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BETTY — Middle CHURCH — Last SCHNEIDER
4. DATE OF DEATH: Month DECEMBER — Day 23, — Year 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 3, 1908
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (County & State, or foreign country): N. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Philip Gordon Church
14. MOTHER'S MAIDEN NAME: Muter Minton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Reginald Schneider — Address: See #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemo thorax — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Metastatic carcinoma — 3 yrs
DUE TO (c): Breast carcinoma — 3 yrs
170X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 64, to 12-23, 19 67 that (I) (~~we~~) lost saw the deceased alive on 12-23 19 67, and that death occurred at 3:15 A M, from causes and on the date stated above.

22a. SIGNATURE: Clarence Chris Tensen M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/26/67
22c. PHYSICIAN'S NAME (Type): O. D. Christensen, Sr,
22d. ADDRESS: S. Division St. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/26/1967
23c. NAME OF CEMETERY OR CREMATORY: Wico. Mem. Park
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland
24. FUNERAL DIRECTOR: Hill Funeral Home — ADDRESS: Salisbury, Maryland
25a. REC'D BY REGISTRAR — DATE: DEC 28 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17840 Item #7 Film #G396 12/27/67 ph

CERTIFICATE OF DEATH

17845

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: RFD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FRANK Middle: JAMES Last: SEARS

4. DATE OF DEATH: Month: DECEMBER Day: 13 Year: 1967

5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAR. 9, 1888
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: POULTRY RAISER
11. BIRTHPLACE (County & State, or foreign country): SOUTH COVENTRY CONN
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS J. SEARS
14. MOTHER'S MAIDEN NAME: MARGARET STEWART

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 072-01-4584
17. INFORMANT: MR. JAMES J. SEARS, Address: OSSINING N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ceased to breathe — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Heart failure — 48 hours
DUE TO (c): Acute myocardial infarction — 48 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-12-67, 19__, to 12-13-67, 19__, that (I) (we) last saw the deceased alive on 12-13 1967, and that death occurred at 11:00 A.M., from causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-13-67.
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Medical Center, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12 17 67
23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAELS
23d. LOCATION (City or Town) (County) (State): BRATTLEBORO WIN. VT.

24. FUNERAL DIRECTOR: Inez A. Burbage
ADDRESS: Berlin Md
25a. REC'D BY REGISTRAR DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17841

CERTIFICATE OF DEATH

17846

1. DECEASED-NAME (Type or print) First: Albert Middle: - Last: Shepherd	2a. DATE OF DEATH Month Day Year: December 11 1967	2b. HOUR: 11 PM	
3. SEX: Male	4. RACE: white	5. DATE OF BIRTH: Sept. 19, 1897	6. AGE (In years lost birthday): 70 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Pine Bluff State Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): painter	12b. KIND OF BUSINESS OR INDUSTRY: -
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Queen Anne's	13c. CITY OR TOWN: Millington	13d. INSIDE CITY LIMITS? YES [X] NO [ ] 13e. STREET AND NUMBER: ✓
14. FATHER'S NAME First: Howard Middle: - Last: Shepherd	15. MOTHER'S MAIDEN NAME First: Mary Middle: - Last: Mahugh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-12-5582	17. INFORMANT: Records of: Address: Pine Bluff State Hospital	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cor. Pulmonale	1 month
DUE TO, OR AS A CONSEQUENCE OF (b)	Emphysema	5 years
DUE TO, OR AS A CONSEQUENCE OF (c)	Pulmonary Tuberculosis	7 years

002.1

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from Dec. 9, 1967, to Dec. 11 1967, that (I) (we) last saw the deceased alive on Dec. 11 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: E P Ritchings	DEGREE: ATTENDING PHYS. [✓] MED. DIRECTOR [X] STAFF PHYS. [ ]	22c. DATE SIGNED: Dec. 12, 1967
22d. PHYSICIAN'S NAME (Type): E. P. Ritchings, M.D.	22e. ADDRESS: Pine Bluff State Hospital	

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: DEC. 14	23c. NAME OF CEMETERY OR CREMATORY: CRUMPTON	23d. LOCATION (City or Town) (County) (State): CRUMPTON MARYLAND
24. FUNERAL DIRECTOR: Edgar L. Lane	ADDRESS: Church Hill, Md.	25a. REC'D BY REGISTRAR DATE: DEC 18 1967	25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4
30M REV. 1/68

CARL Shockley

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17842

CERTIFICATE OF DEATH

17847

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route #6, Dagsboro Road ~~Peninsula General Hospital~~

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Rt. 6, Dagsboro Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CARL — Middle WADE — Last SHOCKLEY
4. DATE OF DEATH: Month December — Day 24 — Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 11, 1899
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Employee
10b. KIND OF BUSINESS OR INDUSTRY: Pump Company
11. BIRTHPLACE (County & State, or foreign country): Pittsville, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Emory Shockley
14. MOTHER'S MAIDEN NAME: Lavinia Figgs
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 215-18-4712A
17. INFORMANT: Mrs. Helen M. Shockley (Wife) — Address: Rt. 6, Dagsboro Rd., Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis, Rt. Lung — INTERVAL BETWEEN ONSET AND DEATH: 4 mos
DUE TO (b) Chronic Obstructive Airway Disease — 5 yrs.
DUE TO (c) Carcinoma, Bronchogenic Rt Lung — 1½ hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1621

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Infection, Pulmonary, Chronic
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from JUNE, 1962 to DEC., 1967, that (I) ~~(we)~~ last saw the deceased alive on DEC. (?) 1967, and that death occurred at 8:30 A.M. from causes and on the date stated above.

22a. SIGNATURE: Rufus S. Gardner M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/24/67.
22c. PHYSICIAN'S NAME (Type): RUFUS S. GARDNER JR
22d. ADDRESS: MEDICAL CENTER, SALISBURY Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 27, 1967
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND — ADDRESS
25a. REC'D BY REGISTRAR — DATE DEC 28 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priot to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17843 Items 8 & 9 Film G396 1/15/68 kk 17848

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LLOYD; Middle L.; Last Smith
4. DATE OF DEATH: Month DECEMBER; Day 27; Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 17, 1896 1897
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State, or foreign country): Willards, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Asbury Smith
14. MOTHER'S MAIDEN NAME: Charlotte Dennis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 213-18-5789A
17. INFORMANT: Mrs. Lula M. Smith (Wife) Address: Willards, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b): Chronic Pyelonephritis — Not Known
DUE TO (c):
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.
6000

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/18/, 19 67 to 12/27/, 19 67 that (I) (we) last saw the deceased alive on 12/26/, 19 67, and that death occurred at 1:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: December 27, 1967
22c. PHYSICIAN'S NAME (Type): Dr. O. J. Burton
22d. ADDRESS: Medical Center, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 29, 1967
23c. NAME OF CEMETERY OR CREMATORY: Truitt Cemetery
23d. LOCATION (City or Town) (County) (State): Willards, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
ADDRESS
25a. REC'D BY REGISTRAR DATE DEC 28 1967
25b. REGISTRAR'S SIGNATURE [signature]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17844 17849

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: North Carolina
b. COUNTY: New Hanover
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington
d. STREET ADDRESS: 715 Pine Grove Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: CHRISTENE — Middle: — Last: SOMERSETT

4. DATE OF DEATH: Month: December — Day: 13 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 29, 1899

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Glouster, Maine

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Brown

14. MOTHER'S MAIDEN NAME: Annie - - - -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 219-10-8559

17. INFORMANT: Mr. Frank Barcus (Son) — Address: Wilmington 8, Delaware 1800 Montclair Ave., Cranston Dr.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-12, 1967 to 12-13, 1967 that (I) (we) last saw the deceased alive on 12-13, 1967, and that death occurred at 12:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Wilber R. Ellis Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: December 14/1967

22c. PHYSICIAN'S NAME (Type): Dr. Wilber R. Ellis, Jr.

22d. ADDRESS: Medical Center, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 16, 1967

23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery

23d. LOCATION (City, town or county) (State): Wilmington, North Carolina

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR — DATE: DEC 18 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7-62

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17845 Items no. 5 & 9 Film #396 12/28/67 km

CERTIFICATE OF DEATH

17850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in 1 d 11/24/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: North Carolina
b. COUNTY: New Hanover
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington 70-3
d. STREET ADDRESS: 715 Pine Grove Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First GEORGE Middle GOLEY Last SOMERSETT
4. DATE OF DEATH: Month DECEMBER Day 15 Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 11, 1911
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Dredge Boat Captain
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Shallotte, N. C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Somersett
14. MOTHER'S MAIDEN NAME: Alice Bland
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 245-12-1359
17. INFORMANT: Mrs. Frank Barcus (Step-son) Address: Wilmington 8, Del. 1800 Montclair Ave., Cranston Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Liver failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b): Acute & Chronic alcoholism, and — 4 years
DUE TO (c): pneumonia — 3 weeks
3221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11/24/, 1967 to 11/15/, 1967, that (I) (we) last saw the deceased alive on 11/14/ 1967, and that death occurred at 3:25 P.M., from causes and on the date stated above.

22a. SIGNATURE: M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: December 15, 1967
22c. PHYSICIAN'S NAME (Type): Dr. O. J. Burton
22d. ADDRESS: Medical Center, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 16, 1967
23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery
23d. LOCATION (City or Town) (County) (State): Wilmington, North Carolina
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
ADDRESS:
25a. REC'D BY REGISTRAR DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17846 Items 8 & 9 Film G397 1/24/68 kk 17901

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: R.F.D.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: JOHN Middle: Last: Stafford
4. DATE OF DEATH: Month: December Day: 30 Year: 1967
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: March 13, 1907
9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: LABORER
11. BIRTHPLACE (County & State, or foreign country): Ala
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Wedlew Ramsey
14. MOTHER'S MAIDEN NAME: Virginia Jackson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Benjamin Ramsey Address: 1726 E. 79th St. Chicago Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic adenocarcinoma — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1992
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): generalized atherosclerosis
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]
20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/29, 1967 to 12/30, 1967 that (I) (we) last saw the deceased alive on 12/29 1967, and that death occurred at 4:35 A.M., from causes and on the date stated above.

22a. SIGNATURE: Earl Beardsley M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 12/30/67
22c. PHYSICIAN'S NAME (Type): Earl Beardsley
22d. ADDRESS: Maryland Ave. Salisbury, Wicomico Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1-4-68
23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Baptist
23d. LOCATION (City or Town) (County) (State): Snow Hill Wcc. Md.

24. FUNERAL DIRECTOR: Loretta B. Jolley ADDRESS: Jersey Rd. Rt 2 Salisbury, Md.
25a. REC'D BY REGISTRAR DATE: JAN 12 1968
25b. REGISTRAR'S SIGNATURE: Charles Jones

1

17847

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2,503 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall 14.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Edna — Last: Strong
4. DATE OF DEATH: Month: December — Day: 1 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 4, 1876
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: T. Romie Strong
14. MOTHER'S MAIDEN NAME: Charlotte Wickes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 215 36 0635
17. INFORMANT: A. - Charlotte Jacquette Address: (Rock Hall (Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO (b) Hypertensive arteriosclerotic cardiovascular disease — Years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart Parkinsonism
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 1/23, 1961, to 12/1, 1967, that I (we) last saw the deceased alive on 12/1 19 67, and that death occurred at 1:10 P M, from causes and on the date stated above.

22a. SIGNATURE: A. C. Mitchell, M.D. M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/1/67
22c. PHYSICIAN'S NAME (Type): A. C. Mitchell, M. D.
22d. ADDRESS: Deer's Head State Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/3/67
23c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery
23d. LOCATION (City or Town) (County) (State): near Chestertown, Md.
24. FUNERAL DIRECTOR: Willis Wells — ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: DEC 5 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17848

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17852

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Headquarters Fire Co. S. Division Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARION — Middle: SLEMONS (ROCK) — Last: TAYLOR
4. DATE OF DEATH: Month: December — Day: 3 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 4, 1884
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Painter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wicomico County, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John D. Taylor
14. MOTHER'S MAIDEN NAME: Emma Ennis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 212-18-6384A
17. INFORMANT: Chief Wilson Taylor — Address: Salisbury Fire Dept., Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer M.D.
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: December 5 /1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 6, 1967
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND — ADDRESS
25a. REC'D BY REGISTRAR — DATE: DEC 7 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

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FOR STATE HEALTH DEPT.

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80

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17849

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17853

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Life Time
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary, Middle Anne, Last Thomas
4. DATE OF DEATH: Month 12, Day 2, Year 19 67
5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-26-67
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months, Days 7; IF UNDER 24 HRS. Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Clarence Thomas
14. MOTHER'S MAIDEN NAME: Elsie Anderson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Clarence Thomas, Address: Princess Anne, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital Heart Malformation. — INTERVAL BETWEEN ONSET AND DEATH: Minutes
7545
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Sudden Death In Infancy
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Boyer M.D.
EXAMINER'S NAME (Type): Earl L. Boyer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

22. DATE SIGNED: 12-4-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/5/67
23c. NAME OF CEMETERY OR CREMATORY: Mt Zion
23d. LOCATION (City or Town) (County) (State): Polk Road, Md

24. FUNERAL DIRECTOR: William H. James Jr. ADDRESS: Princess Anne, Md
25a. REC'D BY REGISTRAR DATE: DEC 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

7-240229

2 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G396 12/20/67 ph

17850

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17854

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 221
d. STREET ADDRESS: Route # 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Dockey — Middle Y — Last Thompson
4. DATE OF DEATH: Month 12 — Day 8 — Year 67 (19)
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 7-20-03
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Harvey Thompson
14. MOTHER'S MAIDEN NAME: Nannie Shackelford
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 215-20-0040
17. INFORMANT: Herman Brooks — Address: Salisbury Md. RD 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b) Arteriosclerotic cardiovascular disease — Years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X] Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22. DATE SIGNED: 12-10-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/10/67
23c. NAME OF CEMETERY OR CREMATORY: St. Stephens Corn Park
23d. LOCATION (City or Town) (County) (State): Delmar Sussex Del

24. FUNERAL DIRECTOR: Marvel Funeral Home Delmar, Del.
ADDRESS:
25a. REC'D BY REGISTRAR DATE DEC 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17851

CERTIFICATE OF DEATH

17855

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Accomack
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Church, VA. 83.3
d. STREET ADDRESS: New Church, VA
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lillie — Middle A. — Last TRADER
4. DATE OF DEATH: Month DECEMBER — Day 16 — Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/8/1881
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: Seamstress
11. BIRTHPLACE (County & State, or foreign country): Atlantic
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John W. Watson
14. MOTHER'S MAIDEN NAME: Mary Thornton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 223-18-6891
17. INFORMANT: Will Gladding — Address: New Church, VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory arrest. — INTERVAL BETWEEN ONSET AND DEATH: 5 days.
DUE TO (b): Right hemiparesis
DUE TO (c): ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-12-67, 19 67 to 12-16-67, 19__, that (I) (we) last saw the deceased alive on 12-16 1967, and that death occurred at 7:10 A.M., from causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-17-67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/19/67
23c. NAME OF CEMETERY OR CREMATORY: Nelson's Ceme
23d. LOCATION (City or Town): New Church — (County): Accomack — (State): VA
24. FUNERAL DIRECTOR: James N. Fox — ADDRESS: Temperanceville, Va.
25a. REC'D BY REGISTRAR DATE: DEC 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17852

CERTIFICATE OF DEATH

17856

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: DELAWARE
b. COUNTY: SUSSEX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FRANKFORD — 46-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: PARIS — Last: TRUITT
4. DATE OF DEATH: Month: December — Day: 29 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: OCT. 10, 1889
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [redacted] MAIL CARRIER
10b. KIND OF BUSINESS OR INDUSTRY: RURAL
11. BIRTHPLACE (County & State, or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: WILLIAM E. TRUITT
14. MOTHER'S MAIDEN NAME: PARISENE TRUITT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 017-26-4318
17. INFORMANT: Wm. A. TRUITT — Address: FRANKFORD, DEL.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac asystole
DUE TO (b): Acute myocardial infarction
DUE TO (c): Coronary atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 7½ hrs

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 12-29, 19 67, to 12-29, 19 67, that (I) (~~we~~) last saw the deceased alive on 12-29-19 67, and that death occurred at 11:55 p M, from causes and on the date stated above.

22a. SIGNATURE: James L. Clifford M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-29-67
22c. PHYSICIAN'S NAME (Type): JAMES L. CLIFFORD
22d. ADDRESS: Medical Center Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1-2-68
23c. NAME OF CEMETERY OR CREMATORY: CAREY'S CEMETERY
23d. LOCATION (City or Town) (County) (State): FRANKFORD, SUSSEX, DEL.

24. FUNERAL DIRECTOR: A. Douglas Melson — ADDRESS: Frankford, Del.
25a. REC'D BY REGISTRAR — DATE: JAN 3 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 5M 6M 1/67

17853 Item 7 Film G396 1/2/68 kk 17857

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. STREET ADDRESS: 1103 Lake Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Elwood Middle Charles Last Tull
4. DATE OF DEATH: Month 12 Day 17 Year 19 67
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1911
9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: BARBER
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Tull
14. MOTHER'S MAIDEN NAME: ANNIE BOSTON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: HENRY TULL Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bullet wound of brain — INTERVAL BETWEEN ONSET AND DEATH: 2hrs. 40M.
981X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during a domestic quarrel.
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:30 A.M. 12-17-67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Oriole (County) (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 12-18-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/22/67
23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Memorial Park
23d. LOCATION (City or Town) Salisbury (County) Wicomico (State) Md.

24. FUNERAL DIRECTOR: Booker West Funeral Home, Salisbury, Md.
ADDRESS:
25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: Florence Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17854

CERTIFICATE OF DEATH

17858

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela
c. LENGTH OF STAY IN 1b: 5 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Maple Shade Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3016 Alisa Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

30.4

90

3. NAME OF DECEASED (Type or print): First: Louise; Middle:; Last: Tull

4. DATE OF DEATH: Month: 12; Day: 14; Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-26-1890
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never Work
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Clay Tull
14. MOTHER'S MAIDEN NAME: Margaret Elizabeth Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Richard M. Dahlstrom Address: 108 White St., Salisbury, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): General Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19 67, to 12/14, 1967, that (I) (we) last saw the deceased alive on 12/14 1967, and that death occurred at 5:10P M, from causes and on the date stated above.

22a. SIGNATURE: H. S. Kuhlman — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-15-1967
22c. PHYSICIAN'S NAME (Type): Dr. H. S. Kuhlman
22d. ADDRESS: Sharptown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-17-1967
23c. NAME OF CEMETERY OR CREMATORY: Nelson Cemetery
23d. LOCATION (City or Town) (County) (State): New Chruch, Va.

24. FUNERAL DIRECTOR: Hill Funeral Home — ADDRESS: Salisbury, Maryland
Norman T. Baker
25a. REC'D BY REGISTRAR DATE DEC 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

17855

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17859

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 236 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield
d. STREET ADDRESS: Calvary Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HATTIE Middle: JANE Last: TYLER
4. DATE OF DEATH: Month: Dec. Day: 17 Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 22, 1885
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: Clothing Mfg.
11. BIRTHPLACE (County & State, or foreign country): Crisfield, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Tyler
14. MOTHER'S MAIDEN NAME: Sarah Lawson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-01-4649
17. INFORMANT: Harold Howard, Sr. — Address: R.F.D. Box 288 Crisfield, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart disease — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
(b) Arteriosclerotic cardiovascular disease — Years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Apr. 25, 19 67, to Dec. 17, 19 67, that (I) (we) last saw the deceased alive on Dec. 17 19 67, and that death occurred at 6:45 A.M., from causes and on the date stated above.

22a. SIGNATURE: W. Maldve, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/17/67
22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.
22d. ADDRESS: Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec.19,1967
23c. NAME OF CEMETERY OR CREMATORY: Crisfield Cemetery
23d. LOCATION (City or Town) (County) (State): Crisfield, Md.
24. FUNERAL DIRECTOR: Levin R. Wilson — ADDRESS: Somerset County, Md.
25a. REC'D BY REGISTRAR DATE: DEC 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

Items 18&21 Film 396
1-8-67 ams
17856

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17860

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sa lisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Delaware
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Selbyville
d. STREET ADDRESS: Route # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clay Middle: Elmer Lost: Waite, Sr.
4. DATE OF DEATH: Month: 12 Day: 25 Year: 19 67

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 24, 1930
9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintance
10b. KIND OF BUSINESS OR INDUSTRY: Factory
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Elmer Waite
14. MOTHER'S MAIDEN NAME: Catherine Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 215-26-4575
17. INFORMANT: Julia Waite Address: Selbyville, Del. R D # 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute alcoholism
3220
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
409 Camden Ave. Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 12-26-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-29-67
23c. NAME OF CEMETERY OR CREMATORY: Lakeside
23d. LOCATION (City or Town) (County) (State): Dover, Kent Del.

24. FUNERAL DIRECTOR: William J. Warwick
ADDRESS: [redacted] Funeral Home [redacted], Del. NEWARK

25a. REC'D BY REGISTRAR DATE: JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17857 Item #8 Film #0396 12/20/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17861

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Lottie Forbes Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manokin
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Henrietta Middle Lost Ward
4. DATE OF DEATH: Month 12 Day 2 Year 19 67

5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-4-1891
9. AGE (In years lost birthday): 75 ~~80~~ yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Fairmount, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Ward
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Anna J. Maddox Address: Manokin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic C.V. Disease
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221
INTERVAL BETWEEN ONSET AND DEATH: Yes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, ~~Undetermined manner~~ ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.
22. DATE SIGNED: 12-4-67

23a. BURIAL, CREMATION, REMOVAL (Specify):
23b. DATE THEREOF: 12-5-67
23c. NAME OF CEMETERY OR CREMATORY: Samuel Wesley
23d. LOCATION (City or Town) (County) (State): Manokin Somerset, Md.

24. FUNERAL DIRECTOR: William J. James III
ADDRESS: 258 Church St. Princess Anne, Md.
25a. REC'D BY REGISTRAR DATE: DEC 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1-68

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17858

CERTIFICATE OF DEATH

17862

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 519 Rose St.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 519 Rose St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertha — Middle: L. — Last: Washington

4. DATE OF DEATH: Month: 12 — Day: 31 — Year: 1967

5. SEX: ~~M~~ Female

6. COLOR OR RACE: C.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/16/1909

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Dashiell

14. MOTHER'S MAIDEN NAME: Annabelle ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Anne Easley — Address: 519 Rose St. Salis. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b) arteriosclerotic cardiovasc disease — 10 mos
DUE TO (c) myocardial ischemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): exogenous obesity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 12/8/67, 19__, to 12/31/67, 19__, that (I) (we) last saw the deceased alive on 12/30 1967, and that death occurred at 5 M, from causes and on the date stated above.

22a. SIGNATURE: Alberta Polin — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/2/68

22c. PHYSICIAN'S NAME (Type): Alberta Mattax Polin

22d. ADDRESS: 707 Camden Avenue, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/4/1968

23c. NAME OF CEMETERY OR CREMATORY: Green Acres

23d. LOCATION (City or Town) (County) (State): Salisbury Wicomico Md.

24. FUNERAL DIRECTOR: Clinton F. Stewart — ADDRESS: Salis. Md.

25a. REC'D BY REGISTRAR: DATE JAN 8 1968

25b. REGISTRAR'S SIGNATURE: J. Charles Jenage

1.

17859

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17863

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital D.O.A.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 204 Brooklyn Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

22-1

3. NAME OF DECEASED (Type or print): First: BARCLAY Middle: HEARNE Last: Wheatley
4. DATE OF DEATH: Month: December Day: 12 Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 22, 1903
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction worker
10b. KIND OF BUSINESS OR INDUSTRY: Builder
11. BIRTHPLACE (County & State, or foreign country): Dorchester County, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George Elmer (Hicks) Wheatley
14. MOTHER'S MAIDEN NAME: Georgia Louise Ellis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 214-07-7759
17. INFORMANT: Mrs. Blanche C. Wheatley (Wife) Address: 204 Brooklyn Ave., Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 12-12, 1967, to 12-12, 1967, that (I) (we) last saw the deceased alive on 12-12 1967, and that death occurred at 7:12 M, from causes and on the date stated above.

22a. SIGNATURE: Wilber R. Ellis Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-12-67
22c. PHYSICIAN'S NAME (Type): Dr. Wilber R. Ellis, Jr.
22d. ADDRESS: Medical Center, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 15, 1967
23c. NAME OF CEMETERY OR CREMATORY: Galestown Cemetery
23d. LOCATION (City or Town) (County) (State): Galestown, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND — ADDRESS
25a. REC'D BY REGISTRAR — DATE: DEC 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17860

CERTIFICATE OF DEATH

17864

M

80

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHITE HAVEN — 22-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dora — Middle: R. — Last: Williams
4. DATE OF DEATH: Month: December — Day: 27 — Year: 1967
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 3,1900
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): ORIOLE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ROBERT ROSS
14. MOTHER'S MAIDEN NAME: REBECCA DAVIS.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: FRANK C. WILLIAMS — Address: WHITE HAVEN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 mo
DUE TO (b): Carcinoma colon — 6 mo
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1538

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11-25, 1967 to 12-27, 1967, that (I) (we) last saw the deceased alive on 12-27 1967, and that death occurred at 6 p.m. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-28-67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/29/1967
23c. NAME OF CEMETERY OR CREMATORY: ORIOLE CEMETERY
23d. LOCATION (City or Town) (County) (State): ORIOLE, MARYLAND
24. FUNERAL DIRECTOR: LEVIN R. WILSON — ADDRESS: PRINCESS, MARYLAND
25a. REC'D BY REGISTRAR DATE JAN 2 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

17861

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17861

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marion Station
d. STREET ADDRESS: P. O. Box 54
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CATHRYN — Middle ISABELLE — Last Wilson
4. DATE OF DEATH: Month DECEMBER — Day 27 — Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 28, 1904
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Medical
11. BIRTHPLACE (County & State, or foreign country): Willis Wharf, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ira Stuart Holland
14. MOTHER'S MAIDEN NAME: Bessie Adams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-30-8804
17. INFORMANT: Carl A. Wilson, Sr., same as 2.abcd — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Necrotizing Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5870

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__, to _____, 19__, that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at 2 P. M, from causes and on the date stated above.

22a. SIGNATURE: Richard E. Hughes M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/2/68
22c. PHYSICIAN'S NAME (Type): Richard E. Hughes, M.D.
22d. ADDRESS: Medical Center - Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 30, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Paul's Cemetery
23d. LOCATION (City or Town) (County) (State): Marion Station, Md.
24. FUNERAL DIRECTOR: Levin R. Wilson - Somerset County, Md. — ADDRESS
25a. REC'D BY REGISTRAR — DATE JAN 8 1968
25b. REGISTRAR'S SIGNATURE: Charles Ludge

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17862 17866

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wicomico Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 204 Marshall Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jessie — Middle: Ellen — Last: Wootten

4. DATE OF DEATH: Month: Dec. — Day: 22, — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept.16,1909
9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teller
10b. KIND OF BUSINESS OR INDUSTRY: Bank
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Parker
14. MOTHER'S MAIDEN NAME: Annie Warren

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 218-20-5974
17. INFORMANT: Mr. N.H.Wootten — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO (b) carcinoma of colon.
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1538

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/1, 1967, to 12/22, 1967, that (I) (we) last saw the deceased alive on 12/22 67, and that death occurred at 5 AM, from the causes and on the date stated above.

22a. SIGNATURE: Paul Beasley M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/22/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-24-1967
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Thomas F. Wallace — ADDRESS: Salisbury, Md.
25a. REC'D BY REGISTRAR — DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: Charles J.

VR A15 (M)
2DM S-63

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 4 & 21 Film G397 2/19/68 kk

17863 **CERTIFICATE OF DEATH** 17867

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1Yr.3Mos.23Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. STREET ADDRESS: 403 Chestnut
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary — Middle MADELINE M. — Last Wootten
4. DATE OF DEATH: Month December — Day 30 31 — Year 19 67
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: MAY 29 1897
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): SUSSEX, DELAWARE
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: FRANKLIN MARVEL
14. MOTHER'S MAIDEN NAME: ANNIE MILLIGAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 Hrs.
DUE TO (b) Hypertensive Arteriosclerotic Heart Disease — Years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Subarachnoid Hemorrhage - Right
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 9/8/66, 19__ to 12/30/67, 19__, that (I) (we) last saw the deceased alive on 12/30/67 19__, and that death occurred at 1P.M. from causes and on the date stated above.

22a. SIGNATURE: Charles H Winnacott M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/30/67
22c. PHYSICIAN'S NAME (Type): Charles H. Winnacott, M. D.
22d. ADDRESS: Box 2018, Salisbury, Md. - 21801

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JAN 2, 1968
23c. NAME OF CEMETERY OR CREMATORY: ODD FELLOWS CEM.
23d. LOCATION (City or Town) (County) (State): SEAFORD SUSSEX DEL
24. FUNERAL DIRECTOR: Fayette M. Watson — ADDRESS: SEAFORD, DEL.
25a. REC'D BY REGISTRAR DATE: JAN 3 1968
25b. REGISTRAR'S SIGNATURE: J Charles Judge